		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044479

Facility Name: CENTURY VILLAGE

Address: 8540 S. HARLEM AVENUE (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (708) 598-2605 **Fax #** (708) 598-5670

IDPA ID Number: 36-4300403

Date of Initial License for Current Owners: 10/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) LEO FEIGENBAUM
(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	404	Skilled (SNF)	404	147,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	404	TOTALS	404	147,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,115	1,591	4,293	24,999	8
9	SNF/PED					9
10	ICF	76,459	3,712	1,352	81,523	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	95,574	5,303	5,645	106,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.24%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 2,942

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	331,951	46,739	15,126	393,816		393,816	0	393,816			1
2	Food Purchase		456,351		456,351		456,351	(1,855)	454,496			2
3	Housekeeping	356,785	57,817	0	414,602		414,602	0	414,602			3
4	Laundry	169,096	32,315	0	201,411		201,411	0	201,411			4
5	Heat and Other Utilities			255,313	255,313		255,313	0	255,313			5
6	Maintenance	156,919	52,375	41,660	250,954		250,954	(4,225)	246,729			6
7	Other (specify):*			127,322	127,322		127,322	0	127,322			7
8	TOTAL General Services	1,014,751	645,597	439,421	2,099,769	0	2,099,769	(6,080)	2,093,689			8
	B. Health Care and Programs											
9	Medical Director	0		2,400	2,400		2,400	0	2,400			9
10	Nursing and Medical Records	2,900,727	198,230	28,437	3,127,394		3,127,394	0	3,127,394			10
10a	Therapy	63,877	1,036	8,955	73,868		73,868	0	73,868			10a
11	Activities	229,168	40,657	2,984	272,809		272,809	0	272,809			11
12	Social Services	95,253		5,712	100,965		100,965	0	100,965			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			3,553	3,553		3,553	0	3,553			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	3,289,025	239,923	52,041	3,580,989	0	3,580,989	0	3,580,989			16
	C. General Administration											
17	Administrative	102,837		204,935	307,772		307,772	66,223	373,995			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			131,820	131,820		131,820	(71,952)	59,868			19
20	Dues, Fees, Subscriptions & Promotions			133,482	133,482		133,482	(92,417)	41,065			20
21	Clerical & General Office Expenses	159,509	37,674	239,517	436,700		436,700	(75,384)	361,316			21
22	Employee Benefits & Payroll Taxes			762,331	762,331		762,331	0	762,331			22
23	Inservice Training & Education			2,396	2,396		2,396	0	2,396			23
24	Travel and Seminar			0	0		0	131	131			24
25	Other Admin. Staff Transportation			2,925	2,925		2,925	276	3,201			25
26	Insurance-Prop.Liab.Malpractice			212,649	212,649		212,649	1,522	214,171			26
27	Other (specify):*			137,047	137,047		137,047	(129,664)	7,383			27
28	TOTAL General Administration	262,346	37,674	1,827,102	2,127,122	0	2,127,122	(301,265)	1,825,857			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,566,122	923,194	2,318,564	7,807,880	0	7,807,880	(307,345)	7,500,535			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CENTURY VILLAGE #0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			169,351	169,351		169,351	(72,591)	96,760			30
31	Amortization of Pre-Op. & Org.			7,218	7,218		7,218	0	7,218			31
32	Interest			183,530	183,530		183,530	(43)	183,487			32
33	Real Estate Taxes			458,412	458,412		458,412	0	458,412			33
34	Rent-Facility & Grounds			2,009,142	2,009,142		2,009,142	0	2,009,142			34
35	Rent-Equipment & Vehicles			31,661	31,661		31,661	16,753	48,414			35
36	Other (specify):* amort. Software			16,028	16,028		16,028	0	16,028			36
37	TOTAL Ownership			2,875,342	2,875,342	0	2,875,342	(55,881)	2,819,461			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		86,716	199,236	285,952		285,952	0	285,952			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			221,190	221,190		221,190	0	221,190			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	86,716	420,426	507,142	0	507,142	0	507,142			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,566,122	1,009,910	5,614,332	11,190,364	0	11,190,364	(363,226)	10,827,138			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(72,591)	30		9
10	Interest and Other Investment Income	(43)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,855)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(15,465)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,433)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,094)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,047)	27		24
25	Fund Raising, Advertising and Promotional	(87,062)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,415)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(4,225)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (325,230)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(37,996)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (37,996)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (363,226)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CENTURY VILLAGE

ID# 0044479

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -4225	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,225)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,855)	0	0	0	0	0	0	0	0	0	0	(1,855)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,225)	0	0	0	0	0	0	0	0	0	0	(4,225)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,080)	0	0	0	0	0	0	0	0	0	0	(6,080)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	66,223	0	0	0	0	0	0	0	0	0	66,223	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,094)	(70,858)	0	0	0	0	0	0	0	0	0	(71,952)	19
20	Fees, Subscriptions & Promotions	(92,910)	493	0	0	0	0	0	0	0	0	0	(92,417)	20
21	Clerical & General Office Expenses	(15,465)	(59,919)	0	0	0	0	0	0	0	0	0	(75,384)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	131	0	0	0	0	0	0	0	0	0	131	24
25	Other Admin. Staff Transportation	0	276	0	0	0	0	0	0	0	0	0	276	25
26	Insurance-Prop.Liab.Malpractice	0	1,522	0	0	0	0	0	0	0	0	0	1,522	26
27	Other (specify):*	(137,047)	7,383	0	0	0	0	0	0	0	0	0	(129,664)	27
28	**TOTAL General Administration**	(246,516)	(54,749)	0	0	0	0	0	0	0	0	0	(301,265)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(252,596)	(54,749)	0	0	0	0	0	0	0	0	0	(307,345)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number CENTURY VILLAGE **#** 0044479 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(72,591)	0	0	0	0	0	0	0	0	0	0	(72,591)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(43)	0	0	0	0	0	0	0	0	0	0	(43)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	16,753	0	0	0	0	0	0	0	0	0	16,753	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(72,634)	16,753	0	0	0	0	0	0	0	0	0	(55,881)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(325,230)	(37,996)	0	0	0	0	0	0	0	0	0	(363,226)	45

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		LIST ATTACHED	LEAF MANAGEMENT		MANAGEMENT	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	ADMINISTRATIVE FEES	$ 70,858	LEAF MANAGEMENT		$	$ (70,858)	1
2	V	21	OUTSIDE CLERICAL	111,837				(111,837)	2
3	V								3
4	V	17	ADMINISTRATIVE FEES				66,223	66,223	4
5	V	20	DUES & SUBSCRIPTION				493	493	5
6	V	21	CLERICAL &OFFICE EXP				51,918	51,918	6
7	V	27	EMPLOYEE BENEFITS				7,383	7,383	7
8	V	24	INSERVICE & SEMINAR				131	131	8
9	V	25	AUTO EXPENSE				276	276	9
10	V	26	GENERAL INSURANCE				1,522	1,522	10
11	V	35	AUTO LEASE				9,993	9,993	11
12	V	35	OFFICE RENT				6,760	6,760	12
13	V								13
14	Total			$ 182,695			$ 144,699	$ * (37,996)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	LEO FEIGENBAUM		ADMIN	14.85	SEE ATTACHED			MAN FEE	$ 68,312	17-8	1
2			BANK, AR								2
3											3
4	ELISHA ATKIN		ADMIN	14.85	SEE ATTACHED			MAN FEE	68,312	17-8	4
5			BANK, PURCH.								5
6											6
7	JOEL ATKIN		ADMIN	14.85	SEE ATTACHED			MAN FEE	68,311	17-8	7
8											8
9	HELEN KAPINUS		Adiministrator	2.48	SEE ATTACHED			SALARY	66,223	17-8	9
10	SALARY FR LEAF										10
11											11
12											12
13								TOTAL	$ 271,158		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LEAD MANAGEMENT, INC
Street Address:
City / State / Zip Code:
Phone Number: (847)470-0000
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE FEES	DIRECT		2	$ 187,160	$ 93,491		$ 66,223	1
2	20	DUES & SUBSCRIPTION	PATIENT DAYS	183,195	4	848		106,522	493	2
3	21	CLERICAL SALARIES	DIRECT		2	14,080	14,080		7,040	3
4	21	CLERICAL &OFFICE EXP	PATIENT DAYS	183,195	4	77,180	53,980	106,522	44,878	4
5	27	EMPLOYEE BENEFITS	PATIENT DAYS	183,195	4	12,698		106,522	7,383	5
6	24	INSERVICE & SEMINAR	PATIENT DAYS	183,195	4	225		106,522	131	6
7	25	AUTO EXPENSE	PATIENT DAYS	183,195	4	474		106,522	276	7
8	26	GENERAL INSURANCE	PATIENT DAYS	183,195	4	2,617		106,522	1,522	8
9	35	AUTO LEASE	PATIENT DAYS	183,195	4	17,186		106,522	9,993	9
10	35	OFFICE RENT	PATIENT DAYS	183,195	4	11,625		106,522	6,760	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 324,093	$ 161,551		$ 144,699	25

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	AMERICAN NATIONAL BANK		X	TERM LOAN	INTEREST	05/01/00	$ 500,000	$ 297,308		9.5000	$ 34,785	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	LINE OF CREDIT	INTEREST	04/10/00		898,413	REVOLV	PRIME +	111,061	6
7	MEMBERS		X	WORKING CAPITAL	INTEREST	10/01/99	436,000	420,000	DEMAND	8.0000	31,540	7
8	INSURANCE		X	INSURANCE FINANCING							6,144	8
9	TOTAL Facility Related						$ 936,000	$ 1,615,721			$ 183,530	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 936,000	$ 1,615,721			$ 183,530	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 424,280	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 441,346	2
3. Under or (over) accrual (line 2 minus line 1).		$ 17,066	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 441,346	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 458,412	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	382,524	8
	1997	405,029	9
	1998		10
	1999	424,280	11
	2000	441,346	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CENTURY VILLAGE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044479

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-403-013-0000	NURSING HOME	$ 441,346.00	$ 441,346.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 441,346.00	$ 441,346.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 112,340 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 36,092
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 7,218
4. Dates Incurred: 10/01/99

Nature of Costs: LEGAL & PRE-OPENING ORGANIZATION COST
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VINYL FLOOR TILE			2000	13,405	487	27.5	487		852	9
10	HAND RAILLS / BUMPER GUARDS			2000	24,298	883	27.5	883		1,546	10
11	DRAPES WITH HARDWARE			2000	17,042	5,453	5	5,453		8,861	11
12	FLOORING POWER BOND CARPET			2000	22,676	7,256	5	7,256		11,791	12
13	WALLPAPER & PAINTING			2000	50,637	12,401	7	12,401		19,637	13
14	HOT WATER STORAGE TANKS & PLUMBING			2000	9,933	361	27.5	361		733	14
15	OVERBED LIGHT FIXTURES			2000	7,754	282	27.5	282		423	15
16	CEILING TILES			2000	4,785	174	27.5	174		261	16
17	CUSTOM NURSES STATION / BUILT WARDROBES			2000	54,060	1,966	27.5	1,966		3,522	17
18	GALVANIZED 4 FOOT FENCE			2000	2,530	169	15	169		259	18
19	LANDSCAPE TREES			2000	6,500	433	15	433		644	19
20	LIGHT FIXTURES			2000	10,158	369	27.5	369		554	20
21	CEILING TILES			2000	1,047	38	27.5	38		57	21
22	STAIR WELL			2000	1,000	36	27.5	36		50	22
23	LIGHT FIXTURES			2000	3,601	131	27.5	131		196	23
24	OUTDOOR SIGN			2000	8,945	325	27.5	325		420	24
25	VINYL TILE IN DINING ROOM & CORRIDOR			2000	24,147	878	27.5	878		1,061	25
26	WALLPAPER & PAINTING / WALL REPAIR			2000	33,129	8,113	7	8,113		12,847	26
27	ROOF TOP A/C UNIT			2000	40,200	1,462	27.5	1,462		1,889	27
28	BASE BOARD HEATER			2000	2,521	92	27.5	92		103	28
29	FIRE ALARM SYSTEM			2000	22,375	814	27.5	814		1,119	29
30	ELECTRICAL - BREAKERS & SWITCHES			2000	4,321	157	27.5	157		164	30
31	NEW ENTRANCE / STEEL DOOR FRAME			2000	45,675	1,661	27.5	1,661		1,729	31
32	ELEVATOR DOOR FRAME PROTECTORS			2000	1,414	51	27.5	51		55	32
33	ELECTRICAL			2001	3,096	61	27.5	61		61	33
34	PT ROOM RENOVATION			2001	48,135	948	27.5	948		948	34
35	DOOR FRAMES			2001	29,062	572	27.5	572		572	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ELEVATOR REHAB	2001	$ 5,850	$ 115	27.5	$ 115	$	$ 115	37
38	WINDOW	2001	1,375	27	27.5	27		27	38
39	DIALYSIS ROOM	2001	10,713	211	27.5	211		211	39
40	DOORS	2001	5,938	117	27.5	117		117	40
41	HOLDING TANK	2001	6,200	122	27.5	122		122	41
42	A/C-HEAT VENTS	2001	16,620	327	27.5	327		327	42
43	FIRE ALARM	2001	2,972	59	27.5	59		59	43
44	A/C UNIT	2001	13,826	272	27.5	272		272	44
45	HAND RAILS	2001	14,191	280	27.5	280		280	45
46	WATER HEATER	2001	2,200	43	27.5	43		43	46
47	FLOORING TILE	2001	32,675	6,535	5	6,535		6,535	47
48	DRAPES	2001	8,830	1,766	5	1,766		1,766	48
49	CARPETING	2001	11,493	2,299	5	2,299		2,299	49
50	WALLPAPERING	2001	16,463	3,293	5	3,293		3,293	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 641,792	$ 61,039		$ 61,039	$ 0	$ 85,820	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 298,458	$ 90,569	$ 29,846	$ (60,723)	10 YRS	$ 44,769	71
72	Current Year Purchases	82,495	16,499	4,125	(12,374)	10 YRS	4,125	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 380,953	$ 107,068	$ 33,971	$ (73,097)		$ 48,894	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			1999	$ 5,249	$ 1,244	$ 1,750	$ 506	3	$ 3,500	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 5,249	$ 1,244	$ 1,750	$ 506		$ 3,500	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,027,994	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 169,351	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 96,760	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (72,591)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 138,214	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER REAL ESTATE LIMITED PARTNERSHIP

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		404	10/01/99	$ 2,009,142	20		3
4	Additions							4
5								5
6								6
7	TOTAL		404		$ 2,009,142 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: 10 YRS PRICE 24365000 *

10. Effective dates of current rental agreement:
Beginning 10/01/99
Ending 09/30/19

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 2,175,035
13.	/2003	$ 2,322,495
14.	/2004	$ 2,445,993

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 16,229 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	FORD SUPER VAN	$ 416.00	$ 5,943	17
18	ELI ATKIN	LEXUS G-5300	649.00	5,289	18
19	HELEN KAPINUS	FORD EXPEDITION	549.00	4,200	19
20					20
21	TOTAL		$ 1,614.00	$ 15,432	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 99,122	$		$ 99,122	1
2	Licensed Speech and Language Development Therapist		hrs			4,808			4,808	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			82,355			82,355	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				86,716		86,716	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): other services					12,951			12,951	13
14	TOTAL			$		$ 199,236	$ 86,716		$ 285,952	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CENTURY VILLAGE **#** 0044479 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (151,849)	$	1
2	Cash-Patient Deposits	1,396,534		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	297,519		6
7	Other Prepaid Expenses	38,494		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow	423,212		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,003,910	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	448,848		15
16	Equipment, at Historical Cost	649,410		16
17	Accumulated Depreciation (book methods)	(297,628)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,967		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	16,884		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due from CRH Property	477,479		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,297,960	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,301,870	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,419,050	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,437		28
29	Short-Term Notes Payable	1,195,721		29
30	Accrued Salaries Payable	287,932		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,060		31
32	Accrued Real Estate Taxes(Sch.IX-B)	441,346		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,391,546	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	420,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 420,000	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,811,546	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (509,676)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,301,870	$ 0	48

***(See instructions.)**

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 153,843	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 153,846	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(663,522)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (663,522)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (509,676)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,526,799	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,526,799	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	43	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,526,842	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,099,769	31
32	Health Care	3,580,989	32
33	General Administration	2,127,122	33
	B. Capital Expense		
34	Ownership	2,875,342	34
	C. Ancillary Expense		
35	Special Cost Centers	285,952	35
36	Provider Participation Fee	221,190	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,190,364	40
41	**Income before Income Taxes (line 30 minus line 40)****	(663,522)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (663,522)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,997	2,177	$ 66,592	$ 30.59	1
2	Assistant Director of Nursing	3,204	3,824	86,820	22.70	2
3	Registered Nurses	25,664	27,767	621,273	22.37	3
4	Licensed Practical Nurses	43,168	44,918	872,803	19.43	4
5	Nurse Aides & Orderlies	111,919	116,204	1,075,566	9.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,090	5,731	63,877	11.15	8
9	Activity Director	2,037	2,086	37,138	17.80	9
10	Activity Assistants	20,546	22,537	192,030	8.52	10
11	Social Service Workers	5,661	5,888	95,253	16.18	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,306	40,405	17.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,075	39,976	291,546	7.29	15
16	Dishwashers					16
17	Maintenance Workers	19,814	20,840	156,919	7.53	17
18	Housekeepers	44,103	46,385	356,785	7.69	18
19	Laundry	21,596	23,527	169,096	7.19	19
20	Administrator	788	829	15,274	18.42	20
21	Assistant Administrator	4,843	5,095	87,563	17.19	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,786	13,936	159,509	11.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca NSG CLERICAL	10,556	11,131	177,673	15.96	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	373,884	395,157	$ 4,566,122 *	$ 11.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 14,490	1-3	35
36	Medical Director	O	2,400	9-3	36
37	Medical Records Consultant	N	1,120	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,653	10-3	39
40	Physical Therapy Consultant	L	1,711	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		84	10a-3	42
43	Speech Therapy Consultant	F	268	10a-3	43
44	Activity Consultant	E	2,984	11-3	44
45	Social Service Consultant	E	5,712	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 35,422		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROB WEISZ	ADMIN		$ 15,274
SUSANNE BLEDSOE	ASST ADMIN	0	18,764
NANCY BROWN	ASST ADMIN	0	33,379
DAVID CHEPLOWITZ	ASST ADMIN	0	12,209
BRENDA DAVIS	ASST ADMIN	0	23,211
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 102,837

B. Administrative - Other

Description	Amount
JOEL ATKIN	$ 68,311
ELISHA ATKIN	68,312
LEO FEIGENBAUM	68,312
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 204,935

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		131,820
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 131,820

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,217
Unemployment Compensation Insurance	65,965
FICA Taxes	346,254
Employee Health Insurance	229,509
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	7,386
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 762,331

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	29,684
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	91,477
DUES RELATED PARTY	493
CONTRIBUTIONS	1,433
DUES & SUBSCRIPTIONS	8,330
LICENSES & PERMITS	2,358
LESS CONTRIBUTIONS	(1,433)
Less: Public Relations Expense	(0)
Non-allowable advertising	(87,062)
Yellow page advertising	(4,415)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,065

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2001	$ 5,071	3 YRS	$	$	$	$ 846	$ 1,690	$ 1,690	$ 845	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,071		$	$	$	$ 846	$ 1,690	$ 1,690	$ 845	$	$

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8080**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,459** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **221,190**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: CENTURY VILLAGE **#0044479** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,490	
	REPAIRS & MAINTENANCE		636	
			0	15,126
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		98,229	
	ELECTRICITY		98,091	
	WATER		58,993	
	CABLE TV - LOBBY		0	
			0	255,313
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		5,071	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		16,346	
	ELEVATOR MAINTENANCE & REPAIR		9,389	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		6,600	
	FIRE SERVICE		4,254	
			0	
			0	
			0	41,660
7	**OTHER**			
	SCAVENGER		29,047	
	SECURITY SERVICE		98,275	127,322
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,400	2,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		289	
	PURCHASED SERVICES		20,231	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,120	
	PHARMACY CONSULTANT	XVIII B 39-2	6,653	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	144	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	28,437
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		1,258	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		546	
	REHABILITATION CONSULTANT	XVIII B __-2	5,088	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,711	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	84	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	268	8,955
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,984	
			0	2,984
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	5,712	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	5,712
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CENTURY VILLAGE **#0044479** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		3,553	3,553
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	204,935	204,935
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,548	
	ADMINISTRATIVE CONSULTANTS	XIX C	70,858	
	PROFESSIONAL FEES	XIX C	46,414	
			0	131,820
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	87,062	
	EMPLOYEE WANT ADS	XIX F	29,684	
	CONTRIBUTIONS	VI 20 XIX F	725	
	DUES & SUBSCRIPTIONS	XIX F	8,330	
	LICENSES & PERMITS	XIX F	2,558	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	4,415	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	708	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	133,482
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		986	
	EQUIPMENT REPAIR & MAINTENANCE		8,242	
	OUTSIDE CLERICAL SERVICES		157,709	
	PENALTIES / OVERDRAFT CHARGES	VI 18	15,465	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		57,014	
	MESSENGER SERVICE		101	
			0	239,517

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	346,254	
	UNEMPLOYMENT COMPENSATION	XIX D	65,965	
	WORKERS COMPENSATION INSURANC	XIX D	113,217	
	HOSPITALIZATION INSURANCE	XIX D	229,509	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,386	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	762,331
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,396	2,396
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,925	2,925
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		212,649	212,649
27	**OTHER**			
	BAD DEBTS	VI 24	137,047	
			0	137,047

GRAND TOTAL COLUMN 3 OTHER 2,318,564

CENTURY VILLAGE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	456,351	PATIENT MEALS	319566
LESS SALES TAX	(1,855)	ADD EMPLOYEE MEALS	0
NET FOOD	458206	TOTAL MEALS/YEAR	319566
TOTAL PATIENT CENSUS	106,522	NET FOOD	458206
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	319566
TOTAL PATIENT MEALS	319566	COST PER MEAL	1.43
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		